Correspondence

Overuse of Health Resources by Penicillin-Sensitive Children

TO THE EDITOR: Regarding the article "Increased Use of Medical Services and Antibiotics by Children Who Claim a Prior Penicillin Sensitivity" in the June 1987 issue,[1] I agree with the authors that allegedly penicillin-sensitive children utilize medical care and antibiotics at a greater rate than other children. But I believe that a possible explanation has been overlooked.

I propose the following: Such children have a higher rate of utilization *before* being labeled as penicillin-sensitive and are more frequently prescribed antibiotics. That is, because they are taken more frequently to physicians, possibly by parents who are more demanding that "something be done," they might more often be given penicillin and its derivatives for exanthem-producing illnesses or gastroenteritides likely to provoke a "reaction." The fact that they are thereafter found to relatively overutilize health resources is merely a continuation and possibly an exacerbation of previously inappropriate behavior on the part of parent and physician alike.

While undoubtedly as guilty as everyone else of inappropriate prescribing of antibiotics, I believe this possible explanation of the observed phenomenon is worthy of investigation.

CHARLES A. PILCHER, MD
12040 NE 128th
Kirkland, WA 98034

REFERENCE

1. Kraemer MJ, Caprye-Boos H, Berman HS: Increased use of medical services and antibiotics by children who claim a prior penicillin sensitivity. West J Med 1987 Jun; 146:697-700

Two Articles in WJM

TO THE EDITOR: As usual, there are two articles in the May 1987 issue that have thoroughly gripped my attention. Not as usual, however, they have left me feeling sad and frustrated rather than educated and uplifted.

John La Puma, MD, describes 27 case consultations in clinical ethics at the University of Chicago from July 1985 to June 1986.[1] As he states, "The referred cases involved a broad range of issues, most of which focused on questions of foregoing one or more life-sustaining therapies in seriously ill patients." Specifically, eight cases involved DNR orders or the limits of care in patients with terminal cancer. Several more cases addressed these same issues in patients with severe, chronic illnesses other than cancer.

What saddens me about this article is not the results. Dr La Puma and his colleagues followed an exemplary format and did thoughtful and caring consultations. What saddens me is the fact that some of these cases required an ethics consultation at all.

Ethics consults can be extremely valuable, both clinically and educationally; indeed, some of the cases presented by La Puma ask hard questions that beg an ethicist's opinion. Still, I cannot help but feel that others of these 27 cases would not have required formal ethics consults if a primary care physician had been involved. Patients with cancer and other chronic illnesses do not deteriorate and die unexpectedly. There ought to be ample time to discuss resuscitation and the limits of care with them and their families well in advance. Such discussions are not routine, however, as Dr La Puma notes: "Busy physicians, even those with an interest in ethics, may tend to marginalize patients' personal values and histories, with these data falling to the side, especially when a patient is critically ill." How sad.

The second article is the editorial on the future of primary care in which the editor calls for more and better research into this discipline. "Discipline?" I wish I knew what discipline it is that you would like to research because I, too, am often frustrated by the lack of recognition given my specialty (family practice) by those who find it too "un-academic."

Unfortunately, I do not think that primary care is a discipline. It is an attitude—an approach, a way of doing medicine—and such things are difficult to research. The combination of scientific, educational and pastoral qualities that create good primary care medicine is not easily studied. When it is, such studies are called "soft" and easily dismissed.

Furthermore, I'm not sure that research into the doctor-patient relationship is the answer. Not that it won't help, but the goal of research is to establish facts—facts which can then be taught and used for future work. How does teaching facts about attitudes make the attitudes themselves useful? Primary care facts may help communicate the existence of primary care attitudes but how will they instill them in physicians? Such research reminds me of the various proofs that God exists.

Values and attitudes—for myself at least—are learned only with difficulty and are not easily taught. Appreciation for the art of patient care may well be enhanced by further investigation of the doctor-patient relationship, general systems theory and models of health education. Art appreciation and art performance, however, are not the same.

MARC TUNZI, MD
Public Health Service
Indian Hospital
Crow Agency, MT 59022

REFERENCES

1. La Puma J: Consultations in clinical ethics—Issues and questions in 27 cases. West J Med 1987 May; 146:633-637

2. Watts MSM: Primary care—Does it have a future? (Editorial). West J Med 1987 May; 146:613

Primary Care—Does It Have a Future?

TO THE EDITOR: In regards to your editorial in the May issue, "Primary Care—Does It Have a Future?,"[1] after 30 years as a general practitioner, I often wonder the same. I am uncertain how to advise students today as to choice of field. Medical educators, if they have any brains, should promote a large body of "family practitioners" and general internists, lest the subspecialists and superspecialists have their time diverted by trivia or common problems

There is no perfect answer. As you alluded to, however, human interaction can still exist in the specialties. I certainly see a lot of specialists who catch on quickly to family dynamics and emotions of their patients.

I don't *want* to be a gatekeeper for the insurance companies (the trend)—it is demeaning, time-consuming at no pay